STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555095	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N M HOLDERMAN MEMORIAL HOSPITAL D/P SNF	100 CALIFORNIA DRIVE YOUNTVILLE, CA 94599

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 8-1-78 K7 SURVEY UNDER: 2000 existing STRUCTURE TYPE: I(332) The following represents the findings of the Department of Public Health, Life Safety Code Unit, during a Life Safety Code Survey of the facility, using the NFPA 101, 2000 Edition (existing), of the Life Safety Code. The Facility was surveyed under 42 CFR 483.70(a) for Long Term Care Facilities. Representing the Department of Public Health: Ken Schmidt, HFE I Census: 204	K 000	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider to the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provisions of Health and Safety Code Section 1250 and 42 C.F.R. 405.1907 (PR ____) initials This Plan of Correction constitutes our written credible allegation of compliance for the deficiencies noted.	
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated	K 017	**K 017 Plan of Correction**: The facility will maintain corridor walls in smoke compartments. The 4 x 5" hole in the wall adjacent to the unit 3B nurse station was patched by Painters. **Responsible:** Plant Operations **Monitor**: Work orders will be submitted to Plant Operations for repair of any walls damaged.	04/14/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Pete DiPrazza — Standards Compliance Coordinator — 4/8/09

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 017	Continued From page 1 walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain the corridor walls in 1 of 22 Smoke Compartments as evidenced by a wall penetration which had the potential to transmit smoke. Findings: During the facility tour with Staff 1 on March 24, 2009, the facility walls and ceilings were observed. At 8:46 a.m., there was an approximately four inch by five inch hole in the wall adjacent to the Unit 3B nurse station.	K 017	**Continued from page 1:**	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	**K 025 Plan of Correction:** The facility will maintain smoke barriers following NFPA 101 Life Safety Code Standards. The 3 x 5" hole in the upper right hand corner of the smoke barrier on unit 3B by the nurse station side of the center corridor was patched by Painters. **Responsible**: Plant Operations **Monitor**: Work orders will be submitted to Plant Operations for repair of any walls damaged.	04/14/09

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K 025	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barriers to provide at least a one-half hour resistance affecting 2 of 22 smoke compartments as evidenced by a hole in one side of a smoke barrier which had the potential to fail to contain smoke during a fire. Findings: During the facility tour with Staff 1 on March 25, 2009, the facility smoke barriers were observed. At 11:00 a.m., there was a three inch by five inch hole in the upper right hand corner of the smoke barrier on the nurse station side of the center corridor smoke barrier on Unit 3B.	K 025	**Continued from page 2:**	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the smoke barriers affecting 22 of 22	K 027	**K 027 Plan of Corrections**: The facility will maintain smoke barriers following NFPA 101 Life Safety Code Standards. The leave of the smoke barrier adjacent to room 3B06 which failed to latch was repaired by the Locksmith at the time of survey. **Responsible**: Plant Operations/Security **Monitor**: Work orders will be submitted to Plant Operations for repair of doors that do not close or latch. Holderman third floor wards will be included in fire drills. **Wards 3B, 3C, and 3E**: Painters are removing paint covering the fire-rating labels on the doors and jambs on wards 3B, 3C, and 3E.	3/24/09

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K 027	Continued From page 3 resident wings and wards as evidenced by door and door frame labels painted over, smoke barrier doors that did not latch and barrier doors held open by non-approved devices which had the potential for non-rated doors to be installed and the failure of the doors to contain smoke during a fire. Findings: During the facility tour with Staff 1 on March 24 and 25, 2009, the facility smoke barriers were observed. At 8:45 a.m. on March 24, 2009, 1 of 2 leaves in the smoke barrier adjacent to room 3B06 failed to latch. At 8:52 a.m. on March 24, 2009, the door frame rating label in the smoke barrier in the central connecting corridor between Wings 3E and 3B were painted over and the door ratings could not be identified. At 8:53 a.m. on March 24, 2009, the door frame rating label in the smoke barrier in the corridor adjacent to room 3E09 was painted over and the door rating could not be identified. At 8:58 a.m. on March 24, 2009, the frame rating label in the smoke barrier in the central connecting corridor between Wings 3E and 3C was painted over and the door rating could not be identified. At 1:35 p.m. on March 24, 2009, the smoke barrier door and frame labels adjacent to the Activity Dining room on Wing 2E were painted over and the ratings could not be identified.	K 027	**Continued from page 3:** Paint staff has been instructed that fire-rating labels on doors and door frames must be covered with blue painters tape before doors and door frames are painted. **Responsible**: Plant Operations **Monitor**: The Painter Supervisor will review painting projects to ensure compliance with regulations. **Wards 1B, 1C, and 1D.** Painters are removing paint from the door frame rating labels on wards 1B, 1C and 1D. Paint staff has been instructed that fire-rating labels on doors and door frames must be covered with blue painters tape before doors and door frames are painted. **Responsible**: Plant Operations **Monitor**: The Painter Supervisor will review painting projects to ensure compliance with regulations. The smoke barrier leave in the main central corridor of ward 1B which failed to latch was repaired by the Locksmith at the time of survey. **Responsible**: Plant Operations **Monitor**: Staff has been instructed to report and submit works orders for repair of doors that do not close or latch. The self-closing doors that were tied open in the attic space above Annex 1, Ward 2 were untied and closed by staff at the time of the survey. Plant Operations checked the rest of the building to ensure compliance. Plant Operations staff will be instructed that all smoke barrier doors in the attic are to be self-closing and latching	4/25/09 4/25/09 3/24/09

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K 027	Continued From page 4 At 1:38 p.m. on March 24, 2009, the smoke barrier door and frame labels in the smoke barrier in the central connecting corridor between Wings 2E and 2C were painted over and the ratings could not be identified. At 1:42 p.m., the smoke barrier door labels in the smoke barrier between Wing 2D and the central connecting corridor were painted over and the ratings could not be identified. At 1:54 p.m. on March 24, 2009, 1 of 2 the smoke barrier door labels in the Wing 2C center unit smoke barrier was painted over and the rating could not be identified. At 2:02 p.m. on March 24, 2009, the smoke barrier door and frame labels in the central corridor between Wings 2E and 2B were painted over and the ratings could not be identified. At 2:08 p.m. on March 24, 2009, the smoke barrier doors and frame labels in the Wing 2E center unit smoke barrier were painted over and the ratings could not be identified. At 2:15 p.m. on March 24, 2009, the smoke barrier frame label in the Wing 2B smoke barrier at the main central corridor was painted over and the rating could not be identified. At 2:17 p.m. on March 24, 2009, the smoke barrier door frame label in the Wing 2B center unit smoke barrier was painted over and the rating could not be identified. At 2:24 p.m. on March 24, 2009, the smoke barrier door and frame labels in the central	K 027	**Continued from page 4:** Additionally staff will be instructed to ensure that all doors are closed upon exiting the attic access. **Responsible**: Plant Operations **Monitor**: Supervising staff will ensure compliance when in the area. The leave in the elevator lobby smoke barrier of ward 3C was repaired by the Locksmith at the time of survey. **Responsible**: Plant Operations **Monitor**: Work orders will be submitted to Plant Operations for repair of doors that do not close or latch. The leave in the smoke barrier door of the central corridor between 3C and 3E was repaired by the Locksmith at the time of survey. **Responsible**: Plant Operations **Monitor**: Work orders will be submitted to Plant Operations for repair of doors that do not close or latch. **Wards 2B, 2C, 2D and 2E.** Painters are removing paint from the door frame rating labels on wards 2B, 2C, 2D and 2E which will include the corridor between wards 2A and 2B. Paint staff has been instructed that fire-rating labels on doors and door frames must be covered with blue painters tape before doors and door frames are painted. **Responsible**: Plant Operations **Monitor**: The Painter supervisor will review painting projects to ensure compliance with regulations.	4/25/09 3/25/09 3/25/09 4/25/09

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K 027	Continued From page 5 corridor between Wings 2A and 2B were painted over and the ratings could not be identified. At 2:45 p.m. on March 24, 2009, the smoke barrier frame label in the Wing 1B smoke barrier at the main central corridor was painted over and the rating could not be identified. At 2:46 p.m. on March 24, 2009, the smoke barrier door frame label in the Wing 1B center unit smoke barrier was painted over and the rating could not be identified. At 2:52 p.m. on March 24, 2009, 1 of 2 leaves in the Wing 1B smoke barrier at the main central corridor failed to latch. At 3:09 p.m. on March 24, 2009, the smoke barrier doors and frame labels in the Wing 1D center unit smoke barrier were painted over and the ratings could not be identified. At 3:11 p.m. on March 24, 2009, the smoke barrier doors and frame labels in the Wing 1C smoke barrier at the main central corridor were painted over and the ratings could not be identified. At 9:12 a.m. on March 25, 2009, 2 of 2 self-closing, rated attic smoke barrier doors were tied open in the attic space above Ward 2 in Annex 1. At 9:25 a.m. on March 25, 2009, 1 of 2 leaves in the smoke barrier in the Wing 3C smoke barrier at the elevator lobby failed to latch. At 10:45 a.m. on March 25, 2009, 1 of 2 leaves in the smoke barrier door in the central corridor	K 027		

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K 027	Continued From page 6 between Wings 3E and 3C failed to latch. NFPA 80 (1999 Edition), 1-5 requires listed items to be identified by a label. Labels shall be applied in locations that are readily visible and convenient for identification.	K 027	**Continued from page 6:**	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to protect hazardous areas from other areas in 1 of 22 resident wings and wards as evidenced by storage room doors that were not self closing which had the potential to fail to contain smoke. Findings: During the facility tour with Staff 1 on March 24, 2009, the hazardous areas were observed. At 9:05 a.m., resident rooms 3D02 and 3D04 were used to store mattresses and equipment. The door to each room was not a self-closing	K 029	**K 029 Plan of Correction:** The facility will ensure hazardous areas are protected from other areas. The doors to the unoccupied resident rooms 3D02 and 3D04 used to store mattresses and equipment were closed. Staff will be reminded that hallways are to remain clear of obstructions and doors to rooms used for storage are to remain closed. **Responsible**: Property, Health/Safety and Nursing Service **Monitor**: Routine inspections by Property, Health/Safety and Nursing Service will be conducted when in the area. Negative findings will be immediately corrected.	4/25/09

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K 029	Continued From page 7 door.	K 029	**Continued from page 7:**	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure exit access in 1 of 22 resident wings and wards as evidenced by an exit door that would not open which had the potential to delay egress in an emergency. Findings: During the facility tour with Staff 1 on March 24, 2009, exit access was observed. At 8:47 a.m., the east exit door from wing 3B would not open.	K 038	**K 038 Plan of Correction:** The facility will ensure that exit access is maintained in resident wings and wards. The Locksmith repaired the east exit door that would not open on ward 3B during survey. **Responsible**: Property, Health/Safety and Nursing Service **Monitor:** Work orders will be submitted to Plant Operations for repair of doors that do not function properly.	04/25/09
K 039 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to keep corridors serving as an exit clear and unobstructed in 2 of 22 resident wings and wards as evidenced by corridor storage which had the potential to delay egress from the facility in an	K 039	**K 039 Plan of Correction:** The facility will ensure aisles or corridors serving as an exit access remain clear and unobstructed. The mattresses stored in the corridor adjacent to the nurse station on ward 3D were moved to storage behind closed doors. Staff will be reminded that hallways are to remain clear of obstructions and doors to rooms used for storage are to remain closed.	

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K 039	Continued From page 8 emergency. Findings: During the facility tour with Staff 1 on March 24 and 25, 2009, the corridors were observed. At 9:05 a.m. on March 24, 2009, there were mattresses stored in the corridor adjacent to the nurse station on Wing 3D. At 8:30 a.m. on March 25, 2009, there was a pallet of equipment stored in the Ward 0 corridor.	K 039	**Continued from page 8:** **Responsible**: Property, Health/Safety and Nursing Service. **Monitor**: Routine inspections by Property, Health/Safety and Nursing Service will be conducted when in the area. Negative findings will be immediately corrected. The pallet of equipment stored in the Annex I, ward 0 corridor was removed. Staff will be reminded to keep aisles or corridors serving as an exit access clear and unobstructed. **Responsible:** Health and Safety **Monitor**: Routine inspections will be conducted by Health/Safety. Negative findings will be immediately corrected.	4/25/09
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on document review, the facility failed conduct fire drills in 4 of 22 resident care Wings and Wards to include activation of the fire alarm and at unexpected times under varying conditions as evidenced by fire drills being conducted at approximately the same time on the NOC shift and failure to activate the fire alarm during the drills which had the potential for staff to fail to react to a fire situation.	K 050	**K 050 Plan of Correction:** The facility will ensure fire drills, which include activation of the fire alarms, occur under varying conditions. Firefighter-Security personnel have received updated training with regard to conducting fire drills. This training included the hours between which the audible alarm does not have to be sounded as well as a review of the process for properly completing the Fire Drill Report. Additionally the Health and Safety Officer has modified the Fire Drill Report form to include question #1A, "If not sounded, was a coded signal given to staff?" The Security Service Policy and Procedure Manual, Section A, has been modified as follows: Fire drills conducted during the first quarter shall be conducted within the first two-hour period of each shift.	4/25/09

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K 050	Continued From page 9 Findings: During the document review on March 24, 2009, the facility fire drill report logs were reviewed. At 1:15 p.m., the facility fire drills for the PM shift in Annex 1 showed 2 of 4 drills being conducted without activation of the fire alarm. At 1:15 p.m., the facility fire drills for the NOC shift in Annex 1 showed 3 of 4 drills being held between 12:20 a.m. and 12:50 a.m.	K 050	**Continued from page 9:** Fire drills conducted during the second quarter shall be conducted within the second two-hour period of each shift. Fire drills conducted during the third quarter shall be conducted within the third two-hour period of shift. Fire drills conducted during the fourth quarter shall be conducted within the fourth two-hour period of each shift. **Responsible**: Security Service **Monitor**: Chief of Security will monitor compliance.	4/25/09
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and document review, the facility failed to maintain the Fire Alarm System in 6 of 22 smoke compartments as evidenced by undated batteries in alarm system panels, corridor room designation lights that failed to function, a pull station that failed to put the system into alarm and the failure to provide final test documents for the fire alarm installation which had the potential for staff not being warned	K 052	**K 052 Plan of Correction**: The facility will maintain the Fire Alarm System in accordance with NFPA 70 National Electrical Code and NFPA 72. The Contractor who conducts fire alarm maintenance for the facility was contacted. The sealed lead acid batteries in the electrical room Notifier Fire Alarm Panel in Annex I, Ward 3, were labeled to reflect the date of installation. The sealed lead acid batteries in the electrical room Fire Alarm Sub-panels in Annex I, Ward 3, were labeled to reflect the date of installation. The Contractor who conducts fire alarm maintenance for the facility was notified of the malfunctioning corridor alarm lights for rooms 2C06 and 3D10. Parts have been ordered to repair the units. **Responsible**: Plant Operations **Monitor:** The Fire Alarm Contractor will check units during their annual inspection of the Fire Alarm System and report findings to Plant Operations.	4/25/09

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K 052	Continued From page 10 in an emergency and system failure. Findings: During the document review and facility tour with Staff 1 on March 25, 2009, the fire alarm system was tested, fire alarm system panels were observed and fire alarm system documents were reviewed. At 8:55 a.m., 2 of 2 sealed lead acid batteries in the Notifier Fire Alarm Panel in the Ward 3 electrical room of Annex 1 were not dated as to when they were installed. At 8:55 a.m., sealed lead acid batteries in 3 of 4 Fire Alarm sub-Panels in the Ward 3 electrical room of Annex 1 were not dated as to when they were installed. NFPA 72 (1999 Edition) Table 7-3.2 requires sealed lead acid batteries in fire alarm system to be replaced every 4 years. At 10:19 a.m., the corridor alarm light for room 3D10 in Wing D failed to active when the room smoke detector was activated. At 11:29 a.m., the corridor alarm light for room 2C06 in Wing C failed to active when the room smoke detector was activated. NFPA 101, 4.6.12.2 requires that "existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed." At 2:07 p.m., the pull station by the Ward 3 patio entrance in Annex 1 annunciated at the building	K 052	**Continued from page 10:** The Fire Alarm Maintenance Contractor was notified of problems identified with the Fire Alarm System during survey. The Contractor came out on March 26 and repaired the module in Annex I, Ward 3. The pull station was reprogrammed to work properly. The Fire Alarm Contractor will check units during their annual inspection of the Fire Alarm System providing logs to Plant Operations identifying issues in need of repair. **Responsible**: Plant Operations **Monitor**: Plant Operations will review testing logs submitted by the Fire Alarm Contractor for items in need of repair. The final documentation approving the installation of the fire alarm system in Annex I was not available at the time of survey. The information has been requested from the installing contractor. A Certificate of Occupancy from the State Fire Marshal for Annex I was provided to the Surveyor prior to his exit. The facility has a service contract for the Fire Alarm System with an outside contractor. The contract is reviewed semi-annually to ensure contract specifications are met. **Responsible**: Plant Operations **Monitor**: Plant Operations will maintain all logs of inspection and testing of the Fire Alarm System as required by NFPA 72.	3/26/09 4/25/09

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K 052	Continued From page 11 fire alarm panel and at the operator panel but failed to put the building fire alarm system into alarm. At 3:45 p.m., the facility failed to provide the final approval documents for the installation of the fire alarm system for Annex 1. NFPA 72 (1999 Edition) 1-6.3 requires a complete, unalterable record of the tests and operations of each system be kept until the next test and for 1 year thereafter.	K 052	**Continued from page 11:**	
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on document review, the facility failed to maintain the smoke detectors in 8 of 22 wings and wards as evidenced by the failure of the facility to provide documentation for the repairs noted on the test report and the failure to document if the test was the initial test or subsequent test which had the potential for detector failure. Findings: During the document review and facility tour with Staff 1 on March 24, 2009, the test records for the fire alarm systems were reviewed and the fire alarm system was tested. At 10:00 a.m., the sensitivity test report for the C	K 054	**K 054 Plan of Correction:** The facility will maintain smoke detectors and activating door hold-open devices in accordance with the manufacturer's specifications. Sensitivity testing of the Holderman C and D wings were located and faxed to the Surveyor on March 30, 2009. The facility will maintain logs of inspection and testing of the Fire Alarm System as required by NFPA 72. The facility has a service contract for the fire alarm system with an outside contractor. The contract is reviewed semi-annually to ensure contract specifications are met. **Responsible:** Plant Operations **Monitor:** Plant Operations will review the inspection and testing logs submitted by the contractor for any issues that need repair.	3/30/09

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K 054	Continued From page 12 and D wings failed to provide documentation for the repair of items that failed and the report failed to document whether the test was the initial sensitivity test or a subsequent test of the detectors. NFPA 72, 7-3.2.1 requires that detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.	K 054	**Continued from page 12:**	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the required automatic sprinkler system in 22 of 22 wings and wards as evidenced by the failure to provide an inspector test valve (ITV) sign which had the potential for accidental opening of the valve and creating a false alarm, as evidenced by the failure to provide	K 062	**K 062 Plan of Correction:** The facility will maintain the automatic sprinkler system in a reliable operating condition and ensure they are inspected and tested periodically. Reports on the weekly testing of the fire pumps for March, April, May and part of June were misplaced by staff. Staff has been informed to forward the weekly testing of the fire pump (churning) to Plant Operations for inclusion into the Fire Pump Testing Logbook. The facility will maintain all logs of inspection and testing of the fire pump per NFPA 25. **Responsible**: Plant Operations **Monitor**: Plant Operations will ensure that all procedures are followed in the testing, inspection and maintenance of the fire pump.	4/25/09

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K 062	Continued From page 13 documentation for weekly fire pump tests for the period of March through June of 2008, the failure to provide documentation for the semi-annual and annual test and maintenance of the fire pump, missing recessed sprinkler head covers and escutcheon rings not flush with the ceiling which had the potential for the sprinkler system to not function properly. Findings: During the document review and facility tour with Staff 1 on March 24 and 25, 2009, the facility automatic sprinkler system was observed and documents were reviewed. At 9:38 a.m. on March 24, 2009, the facility failed to provide documentation for the weekly inspection and test of the fire pump for the period of March through June of 2008. At 9:38 a.m. on March 24, 2009, the facility failed to provide documentation for the fire pump inspection, testing and maintenance required to be done monthly, semiannually and annually. NFPA 25 (1998 Edition) Table 5-5.1 summarizes the fire pump Inspection, Testing and Maintenance frequencies. At 3:02 p.m. on March 24, 2009, 4 of 16 sprinkler heads in the Holderman kitchen area were not flush with the ceiling exposing an approximate one-half inch gap around the pipe where the pipe penetrated the ceiling. At 3:30 p.m. on March 24, 2009, 2 of 2 recessed sprinkler heads in room 1054 were missing the ceiling covers.	K 062	**Continued from page 13:** The facility will initiate a monthly, semiannually and annually preventative maintenance program with proper documentation per NFPA 25. The facility will maintain logs of inspection and testing of the fire pump per NFPA 25. **Responsible:** Plant Operations **Monitor:** Plant Operations will ensure that procedures are followed in the testing, inspection and maintenance of the fire pump. The sprinkler heads in the Holderman Kitchen area were inspected and the escutcheons were realigned back into position by the Plumbers. The two sprinkler heads in Holderman Room 1054 were replaced. Staff has been instructed to notify Plant Operations when escutcheons have fallen down so they can be reinstalled or replaced as necessary. **Responsible:** Plant Operations **Monitor:** Plant Operations will check escutcheons when working in the area. The sign for the Inspector Test Valve (ITV) in Annex I has been ordered and will be installed when it arrives. **Responsible**: Plant Operations **Monitor**: The Fire Alarm Contractor will check all signage when performing inspections and testing of the sprinkler system and will inform Plant Operations if any are missing. Plant Operations will review testing and inspection logs.	4/25/09 4/25/09 4/25/09

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K 062	Continued From page 14 At 1:51 p.m. on March 25, 2009, there was no ITV sign on the ITV for Annex 1. NFPA 13 (1999 Edition), 3-8.3, requires all control, drain, and test connection valves be provided with permanently marked weatherproof metal or rigid plastic identification signs. The sign shall be secured with corrosion-resistant wire, chain or other approved means. At 3:45 p.m. on March 25, 2009, the facility failed to provide the original test record for the Annex 1 fire sprinkler system. NFPA 25 (1998 Edition) 1-8.2 requires original records to be retained for the life of the system and maintained by the owner.	K 062	**Continued from page 14:** The original test records for the Annex I sprinkler system was not available at the time of survey. The facility is requesting the information from the installing contractor. **Responsible:** Plant Operations	4/25/09
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to properly maintain the portable fire extinguishers in 4 of 22 wings and wards as evidenced by extinguishers not having documented monthly inspection, access to an extinguisher blocked and extinguishers stored on the floor which had the potential for the fire extinguishers to fail and delay in reaching the extinguisher. Findings:	K 064	**K 064 Plan of Correction**: Portable fire extinguishers will be maintained in accordance with NFPA 10. The mattress blocking the fire extinguisher adjacent to the ward 3D nurse station was removed and placed in storage behind closed doors. The fire extinguishers in the B, C and D wing elevator rooms, found lying on the floor, were hung on March 27, 2009. Security was notified and instructed to inspect the extinguishers. **Responsible**: Plant Operations/Security **Monitor**: Security will inspect the fire extinguishers monthly and submit a work order to Plant Operations if any need to be hung.	3/27/09

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K 064	Continued From page 15 During the facility tour with Staff 1 on March 24, 2009, the fire extinguishers were observed. At 9:05 a.m., access to the corridor fire extinguisher adjacent to the wing 3D nurse station was blocked by a mattress. NFPA 10, 1-6.6 (1998 Edition), requires that fire extinguishers shall not be obstructed or obscured from view. At 10:13 a.m., the fire extinguisher in the Wing B elevator room had not been inspected since being serviced in January of 2009 and the extinguisher was stored on the floor. NFPA 10, 4-3.1 (1998 Edition) requires fire extinguishers to be inspected at approximately 30-day intervals. NFPA 10, 1-6.10 (1998 Edition), requires extinguishers having a gross weight not exceeding 40 pounds to be installed so that the top of the extinguisher is not more than 5 feet above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 inches (10.2 cm). At 10:15 a.m., the fire extinguisher in the Wing C roof elevator lobby and the fire extinguisher in the Wing C elevator room had not been inspected since being serviced on January 14 of 2009. At 10:22 a.m., the fire extinguisher in the Wing D elevator room had not been inspected since being serviced on January 14 of 2009 and the extinguisher was stored on the floor.	K 064		
K 067	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

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K 067 SS=D	Continued From page 16 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the heating, ventilation and air conditioning system in 1 of 22 resident wings and wards as evidenced by open ducts which had the potential to fail to contain smoke. Findings: During the facility tour with Staff 1 on March 25, 2009, the air conditioning ducts were observed. At 10:32 a.m., the duct and damper access panel at the Wing 3C center corridor smoke barrier was found open. NFPA 90A (1999 Edition) 2-3.5.1 requires air ducts to be located where they are not subject to damage or rupture, or they shall be protected to maintain their integrity.	K 067	**Continued from page 16:** **K 067 Plan of Correction:** The facility will maintain the heating, ventilation and the air conditioning system in accordance with the manufacturer's specifications. The duct and damper access panel in the center corridor of ward 3C was closed by Plant Operations staff on March 25, 2009. Plant Operations staff have been instructed to ensure that duct and dampers are to be closed anytime staff leaves the area. **Responsible**: Plant Operations **Monitor**: Supervising staff will spot check work areas. Negative findings will be corrected immediately.	3/25/09
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	**K 144 Plan of Correction**: The facility will document load levels on emergency generator testing monthly and annually in accordance with NFPA 99. The documentation of weekly generator testing for 1/19/09 and 2/16/09 were not done on those days as they were Holidays.	

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K 144	Continued From page 17 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to document the load level on 2 of 2 emergency generators on a monthly basis or annual basis affecting 22 of 22 wards and wings as evidenced by the failure to provide documentation of the method used to determine the load during the exercising of the generator and the failure to conduct weekly generator inspections for 2 of 52 weeks which had the potential for generator failure. Findings: During the document review on March 24, 2009, the facility generator test and inspection logs were reviewed. At 9:32 a.m., the facility failed to provide documentation for the weekly generator test on or about 2-16-09 and 1-19-09. At 10:02 a.m., the facility failed to provide documentation for the emergency generator load on a monthly or annual basis confirming the generator met the requirements of NFPA 110 (1999 Edition). Staff 1 confirmed this was not done. 6-4.2.2 requires Diesel generators be exercised at least monthly , for minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperature as recommended by the	K 144	**Continued from page 17:** The facility will ensure that weekly visual inspections for the week are conducted the day before or the day after a Holiday, but during the appropriate week. **Responsible**: Plant Operations Electrical Department **Monitor**: Plant Operations Electrical Department will ensure that visual inspections of the generators are conducted during the appropriate timeframe. The emergency generator load levels will be recorded and documented on the Generator Testing Logs. **Responsible**: Plant Operations Electrical Department **Monitor**: Generator Logs will be reviewed by supervising staff to ensure compliance.	3/26/09 3/26/09

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K 144	Continued From page 18 manufacturer. (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating. (3) If the engine cannot be loaded as required in (2), the engine shall be operated until the water temperature and the oil pressure have stabilized and the the test shall be terminated before the 30 minute time period expires. 6-4.2.2 requires Diesel-powered EPS installations that do not meet the requirements of 6-4.2.2 to be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144	**Continued from page 18:**	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the electrical wiring and equipment as evidenced by the failure to provide documentation for polarity testing of the electrical receptacles in 4 of 22 wings and wards which had the potential for electrical shock or fire. Findings: During the document review on March 24, 2009, the facility maintenance records were reviewed.	K 147	**K 147 Plan of Correction**: Electrical wiring and equipment will be maintained in accordance with NFPA 70, National Electrical Code. Plant Operations staff will conduct polarity tests of the electrical receptacles for wards 3B, 3C, 3D and 3E. Wards 3B, 3C, 3D and 3E will be included in their semi-annual testing. **Responsible**: Plant Operations **Monitor:** Plant Operations staff will include Wards 3B, 3C, 3D and 3E test results in the Receptacle Testing Log.	4/25/09

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K 147	Continued From page 19 At 9:15 a.m., the facility failed to provide documentation of polarity testing of the electrical receptacles for wings 3B, 3C, 3D and 3E. Staff 1 stated testing was not done and wings 3B, 3C and 3D were closed and wing 3E was used as offices. NFPA 99 (1999 Edition), 3-3.4.2.3 requires receptacles not listed as hospital grade be tested at intervals not exceeding 12 months.	K 147		